

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017864

FILED VS MAY 12 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1457 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u>		Length of stay in lb <u>2 years 8 mos</u>	c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5401 Arsenal</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Donovan</u> Last <u>Donovan</u>			4. DATE OF DEATH Month <u>April</u> Day <u>21st</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-99</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>1</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Austria</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Anton Kadfensteiner</u>		13b. MOTHER'S MAIDEN NAME <u>Madeline</u>		14. NAME OF HUSBAND OR WIFE <u>George Donovan</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Koett Hosp. RECORD</u> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u>			
DUE TO (c) <u>Pulmonary heart disease</u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic pulmonary tuberculosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
(b) <u>Bronchopneumonia</u>			

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>-</u> Month, Day, Year <u>-</u>			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Aug 8, 1957 to April 21, 1960 and last saw her alive on April 21, 1960  
Death occurred at 12:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Axel R. Ironan, M.D.</u>		22b. ADDRESS <u>Robert Koch Hospital</u>		22c. DATE SIGNED <u>4-22-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis</u>		
24. FUNERAL DIRECTOR <u>Rowland-Aker Mortuary</u> ADDRESS <u>4104 Manchester Av</u> <u>St. Louis 10, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5-3-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Anatomical, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Mary Keener  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.